Name DOB

Health History Form

Welcome to SkinCare Aesthetics. Please take a few moments to complete the following information, this will help us to customize your treatments according to your specific needs.

Cancellation Policy: We are delighted to serve you and have reserved staff and space just for you. If you need to reschedule an appointment please call a minimum of 24 hours prior to your scheduled appointment. If less than 24 hour notice is given you will be charged 50% of the scheduled service price. Prepayment may be asked of patients who fail to show for their appointments.

ALLERGIES

_____ Sulfur/Sulfa _____ Benzoyl Peroxide _____ Citrus _____ Alpha Hydroxy Acids

_____ Hydroquinone _____ Beta Hydroxy Acid/Aspirin _____ Other (please specify) ________________________________

SKIN HISTORY

Specific Concerns (check as many as apply)

_____ Occasional breakout _____ Acne _____ Oiliness _____ Fine Lines

_____ Dryness _____ Sensitivity _____ Sun Damage _____ Uneven skin tone

_____ Fine lines _____ Dehydration _____ Other (please specify___)________________________

_____ Face _____ Neck _____ Back _____ Decollette _____ Hands

_____ Eyes _____ Lips _____ Other: (please specify): ____

History

General health? _____ Excellent _____ Very Good _____ Average _____ Poor

Do you maintain a well balanced diet? _____ Yes _____ No _____ Sometimes

Do you exercise? _____ Regularly _____ Sometimes _____ Never

Do you have a history of: _____ Herpes Simplex (cold sores)

Any medical conditions that we should be aware of: ____

Please list any names that we have authorization to discuss your care with: ________________________

PAST OR CURRENT USE OF THE FOLLOWING MEDICATIONS:

_____ Cleocin _____ Sulfur/Sulfa Meds _____ Retin A/Renova _____ Tazorac

_____ Differin _____ Erythromycin _____ Glycolic Preparations _____ Bleaching Agents

_____ Benzoyl Peroxide _____ Alpha Hydroxy Acids _____ Accutane _____ Beta Hydroxy Acid

_____ Oral Antibiotics _____ Birth Control _____ Other (please specify): ________________________

DEPILATORIES IN USE

_____ Waxing _____ Electrology _____ Chemical Depilatory _____ Laser Hair Removal

_____ Threading _____ Shaving _____ Other (please specify): ________________________

SKIN CARE PRODUCTS IN USE

_____ Cleanser _____ Exfoliant _____ Toner _____ Moisturizer _____ Mask

_____ SPF _____ Other (please specify): ____

BRAND(S) ____

Patient Name (print):________________________________ **Date of Birth:** ________________

Patient Signature: ________________________________ **Date:** ________________